Collaborative partnership between family caregivers and nurses in the care of older hospitalized persons

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CHAPTER **3**

The importance of families in nursing care: Attitudes of nurses in the Netherlands

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Submitted

Abstract

Introduction

Positive attitudes towards family involvement in nursing care are essential for improving involvement of and collaboration with families of patients. The aim of this study is to explore nurses' attitudes towards the importance of families in nursing care.

Method

Using a cross-sectional design, hospital and homecare nurses completed the Families Importance to Nursing Care (FINC-NA) scale, Dutch language version, consisting of four subscales. Data was analyzed using descriptive statistics and regression analyses.

Results

A total of 426 nurses reponded (mean (SD) age 42 yrs (13), 93% female). The results indicate that nurses' attitudes are moderately positive with a mean (SD) total score of 63.8 (12) (100-point scale) on the FINC-NA. Less than half of the nurses (44%) considered family as a collaboration partner, and only 37% of nurses stated that families should be invited to actively participate in planning patient care. The nurses' attitudes were explained by years of work experience in nursing, work setting, and the presence of policy regarding the role of families in patient care.

Conclusion

Nurses in the Netherlands have moderately positive attitudes towards the importance of family in nursing care. However, these attitudes demonstrate that there is room for improvement for establishing the optimal collaboration between patients, nurses, and their families.

Introduction

Family caregivers are providing most of the informal care for home-dwelling older and chronically ill persons in daily life[1] and, therefore, have considerable influence on the health, wellbeing, and self-care of older persons[2-4] Support from health professionals, such as nurses, is almost always temporary and additional in nature. Therefore, it is important for family caregivers to be involved in the nursing care. From this perspective, patients, families, and health professionals should collaborate in order to provide optimal patient care. Involvement of and collaboration with families in nursing care highly depends on nurses' attitudes towards the role and importance of families in patient care.[5,6] Nurses who have positive attitudes towards involving families are more likely to do so in their nursing care.[7-9]

Nurses' attitudes have been studied in various patient populations and healthcare settings5,7,10,11 Attitudes towards families might differ among healthcare settings with those of home care nurses being more positive compared to nurses working in the hospital setting.[5,12] Nurses with a higher educational level and more years of work experience also demonstrate attitudes that are more positive towards families[5,10,11,13] Nurses' knowledge about policy regarding family involvement being present in the organization is also known to positively influence their attitudes.[5,12]

There is an increasing awareness towards the importance of family caregivers in the care for the elderly and chronically ill in health care in societies like the Dutch.[14] A previous study found differences of nurses' attitudes across European countries,[13] showing the importance of country specific information. However, in the Netherlands, nurses' attitudes have not yet been measured. Therefore, the aim of the study was to describe their attitudes towards the importance of families in nursing care and to investigate the contribution of professional and demographic characteristics to these attitudes. Insight into nurses' attitudes towards families is necessary in order to establish adequate policy, strategies, and targeted interventions to improve family involvement in nursing care.

Method

A cross-sectional design was used and data were collected with an online survey among nurses in 15 wards of four general hospitals and one home healthcare organization in the northern part of the Netherlands.

Sample and setting

The sample of this study initially consisted of 1,211 nurses; 403 hospital and 808 home health care nurses and nursing aids. Participating hospital wards were cardiology (3), internal medicine (3), pulmonology (4), neurology (4), and one geriatric nursing ward. The home health care organization self selected a region in the Netherlands to participate in the study. Those included in this study had earned an associate degree level 4 (a four-year course at a community college, including technical nursing interventions) and a bachelor degree or master degree in nursing.[15]

Measurements

Instrument

In order to measure nurses' attitudes, the Dutch version of the Families' Importance in Nursing Care–Nurses' Attitudes (FINC-NA) was used.[16] The FINC-NA consists of 26 items divided into four subscales: *Family as its own resource* (Fam-OR) referring to families' own resources for coping (four items); *Family as a burden* (Fam-B) referring to statements of experiencing family as a burden (four items); *Family as a conversational partner* (FAM-CP) referring to the acknowledgment of the patients' family members as conversational partners (eight items), and *Family as a resource in nursing care* (Fam-RNC) referring to a positive attitude toward families' presence in nursing care (ten items). Internal consistencies of the instrument are good with Cronbach's alphas ranging between 0.88 and 0.90 for the whole instrument. [9,16,17] The FINC-NA uses a five point-Likert scale (Strongly agree, Agree, not Agree/not Disagree, Disagree, and Strongly disagree). The item scores range from 5 to 1 with scores ranging from 26 – 130 for the whole instrument. The higher the score, the more supportive the nurses' attitudes are toward families in nursing care. The four "negatively" formulated items of the subscale family as a burden were subsequently reversed to facilitate data analysis.

Nurses' characteristics

The survey consisted of a set of questions regarding demographic and professional characteristics such as age, gender, years of work experience, highest level of education in nursing, knowledge of policy on families being present in the organization, training in family nursing, and experience as an informal caregiver of a critical ill family member.

Ethics

The medical ethics committees of the organizations involved granted permission to conduct the study as described. Prior to the beginning of the study, nurses were informed of the study purposes and data processing. Nurses voluntarily participated in it and gave their consent for participation and publication of the results before completing the online survey. Responses were received anonymously and, therefore, could not be traced back to any individual person.

Procedure

The FINC-NA instrument was transferred into a web application. An invitation containing a personalized link to the survey was sent to nurses' work e-mail addresses. After two or four weeks, a reminder was automatically sent to all e-mail addresses in the event that no response had yet been received. The web application had the ability to automatically send reminders after a set period of time to all e-mail addresses that had not yet responded. This process was blinded for all persons, including the researcher.

Data-analyses

Data were entered into SPSS version 24.0.[18] Descriptive statistics were used to detail the characteristics of the study population and responses to the FINC-NA questionnaire on (sub)scale and item levels. Respondents who had more than five items (20%) of the 26 items missing or those who had more than 20% missing on a subscale were omitted from further analysis. Missing values were replaced through SPSS by the method of series means.[19] Because the subscales consist of an unequal number of questions, all of the four subscales were transformed to a 100-point scale in order to better interpret the differences in attitudes per subscale.

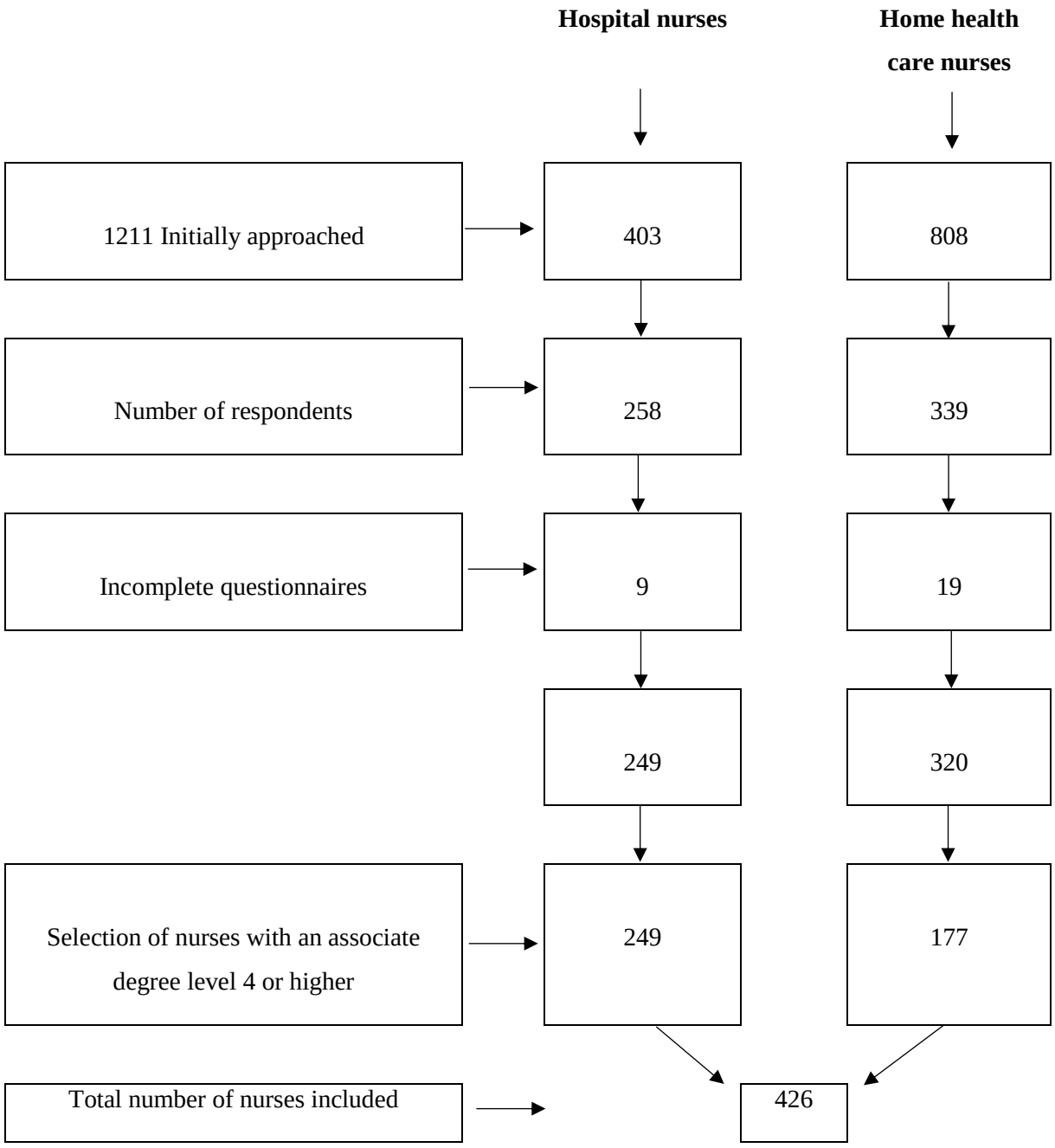
Multivariate linear regression analyses were performed to identify the individual contribution of the demographic, organizational, and professional factors to the FINC-NA total score and subscale scores. The variables age and years of work experience appeared to be highly correlated (Spearman's rho .85, $p < 0.00$). In order to avoid collinearity, only years of work experience were entered in the regression models. The regression analysis was performed using the Backward method, and outcome parameters were expressed in Beta, the standardized version of *b*-values. These values are easier to compare because they are not dependent on the units of measurement of the different parameters but measured in standard deviation units.[20] The *p*-level for statistical significance was set at 0.05.

Results

Sample

Initially, 597 nurses and nursing aids responded to the online survey (49%) of whom 426 (35%) had an associated degree level 4 or higher and, therefore, were eligible to participate in the study (see Figure 1).

Figure 1. Flowchart of eligible respondents



The sample involved 249 hospital and 177 home care nurses. Only four (0.9%) respondents had one missing item at random concerning items B2, CP2, OR2, and RNC8. These missing items were replaced by the series mean.

Table 1. Nurses' characteristics (N=426)

Characteristic	**Mean (SD)**
Age	42 (13)
Years of work experience	18.8 (12.4)
	N (%)
Gender	
Female	398 (93)
Male	28 (7)
Informal caregiving experience	
Yes	280 (66)
No	146 (34)
Highest level of nursing education in nursing	
Associate degree*	253 (60)
Bachelor degree	150 (36)
Master degree	15 (4)
Training in family nursing	
Yes	64 (15)
No	362 (85)
Work setting	
Hospital	249 (59)
Homecare	177 (41)
Policy present on families	
Yes	188 (44)
No	238 (56)

*Associate degree level 4 (a four-year course at a community college, including technical nursing interventions).

In Table 1, nurses' demographic and professional characteristics are depicted. The average (SD) age was 42 (13), and 93% of the nurses were female. Most nurses (85%) stated that they had not had any continuing education in family care.

Nurses' Attitudes towards the importance of families in nursing care

As shown in Table 2, the mean (SD) score on the total FINC-NA scale was 84.6 (11.5) on the theoretical range of 26 to 130 and was 63.8 (12.0) when converted to a 100-point scale. Nurses' attitudes towards families as a conversational partner and as their own resource were lowest with mean scores (SD) of 59 (14.9) and 60 (18), respectively, based on the 100-point range. Nurses did not consider families as a burden which was reflected by the highest score of 73.9 (17.0) on the reversed Burden sub-scale.

Table 2. FINC-NA total scale and subscale scores

(Sub)scale(s)	**Range**	**Mean (SD)** **Raw score**	**Mean (SD)** **100-point range ***
Fam-OR	4-20	13.6 (2.7)	60.0 (18.0)
Fam-CP	8-40	26.9 (4.8)	59.0 (14.9)
Fam-RNC	10-50	28.3 (4.6)	65.5 (13.1)
Fam-B**	4-20	15.8 (2.7)	73.9 (17.0)
FINC-NA (total)	26-130	84.6 (11.5)	63.8 (12.0)

*based on a 100- point scale; ** scale was reversed.

In Table 3, the percentages of responses and mean scores of the sub-scales of the FINC-NA are provided. The items of the subscale 'family as own resource' show that only 18% of the nurses consider family members as co-operating partners or encourage families to use their own resources so that they can cope with their situation with mean item scores of 3.3 and 3.6, respectively. Over half (57%) of the nurses see themselves as a resource for families for coping with the care situation (mean item score 3.3). Items of the subscale *'family as a conversational partner'* show that most nurses (82%) strongly agreed with the statement 'it important to find out who belongs to the family', and 81% strongly agreed to the statement 'I invite family members to speak about changes in the patient's condition' with mean items scores of 4.3 and 4.2, respectively.

Table 3. Percentages of responses and mean values of nurses' responses

Subscales and items	Percentages of responses (%)		Mean (SD)
	(strongly) disagree	(strongly) agree	
Family as its own Resource			
I encourage families to use their own resources so that they have the optimal possibilities to cope with situations by themselves	18	46	3.3 (.96)
I see myself as a resource for families so that they can cope as well as possible with their situation	12	57	3.6 (.94)
I consider family members as co-operating partners	18	44	3.3 (.96)
I ask families how I can support them	21	45	3.3 (1.0)
Family as a conversational partner			
I invite family members to have a conversation at the end of the care period	33	35	3.0 (1.2)
I ask family members to take part in discussions from the very first contact when a patient comes into my care	36	36	3.0 (1.2)
I always find out what family members a patient has	25	45	3.3 (1.1)
I invite family members to speak about changes in the patient's condition	3	81	4.2 (.86)
I invite family members to speak when planning care	43	20	2.7 (1.0)
It is important to find out what family members a patient has	5	82	4.3 (.89)
I invite family members to actively take part in the patient's care	36	26	2.9 (1.0)
Discussion with family members during first care contact saves time in my future work	16	51	3.4 (.94)
Family as a resource in nursing care			
The presence of family members eases my workload	13	32	3.2 (.76)
The presence of family members gives me a feeling of security	39	13	2.7 (.93)

Table 3. continued

Subscales and items	Percentages of responses (%)		Mean (SD)
	(strongly) disagree	(strongly) agree	
The presence of family members is important to me as a nurse	7	67	3.8 (.88)
Family members should be invited to actively take part in the patient's nursing care	10	51	3.6 (.91)
Family members should be invited to actively take part in planning patient care	25	37	3.1 (1.0)
A good relationship with family members gives me job satisfaction	2	84	4.3 (.78)
Getting involved with families gives me a feeling of being useful	5	68	3.8 (.87)
I gain a lot of worthwhile knowledge from families which I can use in my work	8	66	3.8 (.92)
The presence of family members is important for the family members themselves	5	68	3.8 (.81)
It is important to spend time with families	3	78	4.0 (.77)
Family as a burden*			
The presence of family members makes me feel that they are checking up on me	68	10	3.8 (.96)
The presence of family members makes me feel stressed	76	4	4.1 (.89)
The presence of family members holds me back in my work	83	6	3.9 (.87)
I don't have time to take care of families	67	7	3.9 (.97)

* The four "negatively" formulated items of the subscale family as a burden were subsequently reversed to facilitate data analysis.

Furthermore, a minority of nurses (36%) actively invites family members for discussion at the start of the care period, invites families when planning care (20%), or invites families to take an active part in patients' care (26%) with mean item scores of 3.0, 2.7 and 2.9, respectively (See Table 3).

Table 3 also shows that, within the subscales '*family as a resource in nursing care',* most nurses (strongly) agreed (84%) with the statement 'a good relationship with family members gives me job satisfaction', and 78% (strongly) agreed with the statement 'it is important to spend time with families' with mean item scores of 4.3 and 4.0, respectively. A total of 66% of nurses agreed with the statement, 'I gain a lot of worthwhile knowledge from families which I can use in my work', but only 37% of nurses agreed that 'family members should be invited to actively take part in planning patient care' with mean item scores of 3.8 and 3.1 respectively. A minority (13%) of nurses (strongly) agreed with the statement 'the presence of family members gives me a feeling of security' (mean item score 2.7).

Most nurses did not perceive family as a burden in nursing care with mean item scores varying from 3.8 to 4.1. (Table 3).

Factors contributing to positive attitudes

As shown in Table 4, the different models show a small but significant relationship between nurses' attitudes and years of work experience as a nurse (Beta = .204, $p < .001$) and the presence (or absence) of policy regarding families (Beta= -.154, $p = .001$), work setting (hospital vs home care) Beta= .130, $p = .007$), and the highest level of nursing education (Beta= .101, $p = .036$). Almost all of the scales indicated years of work experience to be of significant value for the model except for the model regarding the FamRNC. Although the explained variance of the model regarding subscale B is very low (4%), experiencing family as a burden appears to be primarily related to nurses' years of work experience (B = .167, $p < 0.05$). With regards to the FamRNC, female gender also seems to be significant for nurses' attitudes (B = -.098, p = 0.046). The subscale FamOR showed the highest proportion of explained variance (20%); nurses' attitudes within this scale were explained by years of work experience (B = .195, $p < 0.001$), work setting (B = .34, $p < 0.001$), and policy (B = -.108, $p = 0.015$). The variables 'continuing training in family care' and 'informal caregiving experience with an ill relative' did not seem to be of influence on nurses' attitudes towards family importance in nursing care.

Table 4. Linear regression models for the total FINC-NA and subscales

	FINC-NA total		**Fam OR**		**Fam- CP**		**Fam RNC**		**Fam-B**	
Variable	Beta	*p-value*	Beta	*p-value*	Beta	*p-value*	Beta	*p-value*	Beta	*p-value*
Gender (0= female)							-.098	.046		
Years of work experience	.204	<.001	.195	<.001	.194	<.001			.167	.001
Family member with serious illness[1] (0=Yes)										
Highest level of nursing education	.101	.036								
Continuing training in family care[2] (0=Yes)										
Work setting (0= hospital)	.130	.007	.340	<.001						
Policy present on families[3] (0=Yes)	-.154	.001	-.108	.015	-.170	<.001	-.114	.020		
Model statistics										
F	10.98		33.97		10.04		5.23		5.96	
Significance	<.001		<.001		<.001		.006		.001	
R square	.096		.198		.068		.025		.042	

[1] Do you have or have had a family member with a serious illness who needs professional care?

[2] Have you attended specific training that concerns support or collaboration with families of patients?

[3] Is there a general approach to the care of families at your place of work?

Discussion

This study is the first to describe nurses' attitudes towards the importance of families in nursing care in the Netherlands. Results indicate that nurses' attitudes are moderately positive with a mean (SD) total score of 63.8 (12) (on a 100-point score) on the FINC-NA. The results also show that only 37% of nurses state that families should be invited to actively participate in planning patient care, and less than half of the nurses (44%) consider families as a collaborating partner. On the other hand, most of the nurses (82%) state that it is important to find out who the patient's family members are or who spends time with them (78%). Findings also show that nurses' attitudes towards families as conversational partners and families as their own resource are low compared to their attitudes towards families as a burden. The nurses' attitudes in this study were mainly explained by the presence of policy regarding families in nursing care and years of work experience in nursing.

The results indicate that nurses do not seem to perceive families as an important factor for nursing care considering that the mean total scores of the subscales Fam-CP, Fam-OR, and Fam RNC are moderate with scores of 59, 60, and 65.5 (based on 100-point scale), respectively. The mean total score on the FINC-NA of this study falls within the outcomes of other studies.[5,8,9,17,21] The results of the mean scores on the subscales are comparable to other studies although it seems that Dutch nurses experience families less as a burden and also less as a resource in nursing care.[5,8,9,17,21]

In the context of a rapidly changing society and a health care system in the Netherlands in which it is expected that patients increasingly rely on the support of family caregivers in dealing with their health challenges, this finding can be considered as worrisome. Nurses and other health care professionals in general must become aware of the increasing importance of the caregiving role of family caregivers for their patients and the need to acknowledge these caregivers as collaborative partners in care.[22,23] Furthermore, there seems to be a discrepancy between nurses' attitudes and their actual behavior; 82% of the nurses (strongly) agree with the statement that it is important to determine who belongs to the family of the patient, but only 45% of these nurses agree with the statement 'I always find out who belongs to the family'. Positive attitudes, therefore, do not automatically assure corresponding behavior.

Results show that the presence of policy within organizations on families appears to be a factor influencing attitudes of nurses, as was also found in other studies.[5,12] As more than

half of the nurses (56%) indicate that, to their knowledge, this policy is not present, this seems to be an area in which additional attention must be paid. In general, it can be stated that (written) policy and consensus among staff on the role of families and how to involve them in patient care is crucial in terms of implementing high quality patient care. Nurses and nursing organizations should take responsibility to contribute to the development of organizational policies that are aimed towards active involvement of families in order to support and improve the implementation of a more family-oriented approach in health care.

In this study, years of work experience as a nurse was also of influence for nurses' attitudes. Nurses with a limited number of years of work experience had significantly fewer positive attitudes towards the importance of families. This is consistent with other studies.[5,11-13] Based on the ideas of Benner,[24] this is mostly explained by the belief that less experienced nurses may still be in the process of learning skills and gaining expertise with a greater focus on their relationship with the patient and on physical care and patient safety;[21] caring for family is of less priority. Regarding this aspect, nursing education has an important role to play; nursing students need to develop competencies (knowledge, skills, and attitudes) in collaborating with families as an integral part of their nursing education.

In accordance with other studies, this study also indicates that home care nurses show a more positive attitude compared to hospital nurses on the total FINC-NA scale and the subscale family as its own resource.[5,12,21] As home care nurses care for persons within their own living environment, they may find it more logical to view the patient and their social network as relevant and, consequently, collaborate with family caregivers on behalf of the patient care. In a home care situation, the nurse adheres to the system of the patient and family caregiver but, in the hospital, the patient adheres to the system of the hospital.

This study focused specifically on nurses' attitudes towards the importance of families in nursing care and was measured with a valid FINC-NA Dutch language scale. Results show that there is room for improvement, especially regarding families as conversational partners and as their own resource in nursing care. The importance of family involvement in care should be an explicit matter of concern for nurse educational institutions and for policy making within health care organizations.

Limitations

The fact that this study was based on a self-selected convenience sample of nurses working in the hospital setting and in the home care setting may have caused some bias; non-respondents may represent nurses with less positive attitudes towards the importance of family.

Conclusion

In conclusion, nurses in the Netherlands seem to have a moderately positive attitude towards the importance of family in nursing care. Considering the current changes that are occurring in the Dutch health care system, there is also a need for improvement in nurses' attitudes in order to establish a collaborative partnership between patients, nurses, and their families.

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